STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS
DEPARTMENT OF HUMAN SERVICES
600 NEW LONDON AVENUE
CRANSTON, RI 02920

DURABLE MEDICAL EQUIPMENT* - CERTIFICATE OF MEDICAL NECESSITY

RECIPIENT NAME_____
(FIRST NAME) (MIDDLE INITIAL) (LAST NAME)

RECIPIENT'S ADDRESS (WHERE EQUIPMENT WILL BE USED)
(IF NURSING HOME, GROUP HOME, INSTITUTION-GIVE NAME)

_____

MEDICAID IDENTIFICATION NUMBER_____

DIAGNOSIS_____
(INCLUDE ICD-9 CODES)

PROGNOSIS_____

PATIENT STATUS: CHECK ALL CONDITIONS APPLICABLE

( ) Confined to room
( ) Confined to chair
( ) Confined to bed
( ) Disoriented
( ) Body positioning required that would not be feasible in an ordinary bed
( ) Periodic movement necessary to retard deterioration
( ) Substantial therapy required under MD's supervision
( ) Ambulation impaired
( ) Other

DURABLE MEDICAL EQUIPMENT OR SUPPLIES NEEDED _____

_____

Please explain any special feature, such as electrically operated bed or wheelchair or special feature glucose machine, required because disability precludes the use of standard equipment.

_____

_____

DATE OF SERVICE_____

DURATION OF NEED ( ) NUMBER OF MONTHS ( ) INDEFINITELY
( ) PERMANENTLY ( ) OTHER

PRESCRIBING PROVIDER'S NAME_____
(PLEASE PRINT)

PRESCRIBING PROVIDER'S SIGNATURE_____

**THIS FORM IS NOT TO BE USED FOR OXYGEN THERAPY*